STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G219	A. BUILDING _____ B. WING _____	08/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HOMES, INC	615 55TH STREET, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A recertification survey was conducted from August 24, 2011 through August 26, 2011. A sampling of three clients was selected from a population of five males with cognitive and intellectual disabilities. This survey was conducted utilizing the fundamental survey process. The findings of the survey were based on observations and interviews with staff in the home and at two day programs, as well as a review of client and administrative records, including incident and investigation reports. [Qualified Mental Retardation Professional(QMRP) will be referred as Qualified Intellectual Disabilities Professional (QIDP) within this report.]	W 000	Recevd 9/21/11 Department of Health Health Regulation & Licensing Administration Intermediate Care Facilities Division 899 North Capitol St., N.E. Washington, D.C. 20002	
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that each client's active treatment program was coordinated, integrated and monitored by the qualified intellectual disabilities professional (QIDP), for three of three clients in the sample (Clients #1, #2 and #3). The findings include: 1. Cross refer to W249. The facility's QIDP failed to ensure Clients #1 and #3 received continuous	W 159	W159 1. The staff involved has been disciplined and re trained in this individual's mealtime protocol. The QDDP and the RC/RN will ensure that they monitor the staff during mealtimes at least 2x/week, to ensure that the mealtime protocol is being followed. 2. All staff were in serviced on IPP documentation and accurate data collection. 3. The QDDP will ensure that staff are trained and are able to monitor the correct use of the elbow pads and the foot box. The QDDP will ensure that the staff documents on a daily basis the condition of each of the adaptive equipment being used by the individuals. All staff were in serviced on the daily adaptive equipment monitoring form. All staff were in serviced on IPP documentation. See attached in service records	9/21/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Susan L. Sloan	VP Operations	9/20/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 159	Continued From page 1 active treatment. 2. Cross refer to W252. The facility's QIDP failed to ensure program documentation was accurately collected for Client #3. 2. Cross refer to W436. The facility's QIDP failed to failed to ensure that recommended assistive devices was maintained in good repair Clients #1 and #2.	W 159		
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility's qualified intellectual professional (QIDP) failed to ensure clients received continuous active treatment, for two of the three clients included in the sample. (Client #1 and #3) The findings include: 1. On August 25, 2011, beginning at 6:36 p.m., the direct support staff was observed feeding Client #3 his dinner with hand over hand assistance. One minute later, the direct support staff placed the client's spout cup in his mouth	W 249	W249 1&2.All staff were re trained on Mealtime Protocol and IPP. In the future the QDDP and RC, RN and LPN will ensure that staff are observed on at least a weekly basis during mealtimes and there is documentation and teaching completed. See attached mealtime protocol IPP – inservice record	9/21/11

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W 249	Continued From page 2	W 249		

without the use of hand over hand assistance. At 6:46 p.m., the direct support staff began to feed the client his meal without hand over hand assistance. At 6:55 p.m., the direct support staff spoon fed the client his chocolate pudding.

Interview with the direct support staff on August 25, 2011, at 7:05 p.m., revealed she " did not think the client wanted to hold his built up handle spoon. "

Review of Client #3's occupational assessment dated April 24, 2011 on August 26, 2011, at approximately 10:45 a.m., revealed the client will hold his spoon and participate with assistance.

Review of Client #3's individual program plan (IPP) dated April 25, 2011 on August 26, 2011, at 11:00 a.m., revealed an objective that stated, "Given hand over hand assistance, [the client] will feed himself with five spoons during meals on 80% of trials for six consecutive months by April 2012." Further review of the IPP revealed the following steps:

a. The client will be verbally prompted by staff to hold his spoon;

b. Staff will assist to scoop food on spoon and gently prompt the client to bring food to his mouth;

c. Staff will encourage and reinforce the client when he completes directives;

d. Staff will allow the client to perform as his level permits and document the number of times;

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W 249	Continued From page 3 Interview with the QIDP on August 26, 2011 at approximately 10:30 a.m., revealed she will retrain the staff on Client #3's IPP. There was no evidence that the facility implemented Client #3's IPP as recommended. 2. On August 25, 2011, beginning at 6:38 p.m., Client #1 was observed eating at a fast pace. At 6:42 p.m., the client drank water as the house manager placed the spout cup to his mouth. The client then began to eat at a fast pace again. The house manager gently placed her hand on top of his left hand as the client ate fast with his right hand. At 6:44 p.m., the house manager asked the client to slow down. The client then began to feed himself at a slower pace with verbal prompting. At 6:52 p.m., the house manager began to feed the client the rest of his dinner. At 6:54 p.m., the house manager spoon fed the client his chocolate pudding. Interview with the house manager on the same day at 7:00 p.m., revealed the client eats fast and she "did not want his food to get everywhere". Review of Client #1's occupational assessment dated November 4, 2010 on August 26, 2011, at 9:20 a.m., revealed the client eats fast and needs prompts from staff to slow down. On the same day, at approximately 9:30 a.m., review of Client #1's IPP dated November 1, 2010, revealed an objective that stated, "Given verbal prompts, [the client] will eat at a slow pace during meals on 80% of trials for six consecutive months by November 2011". Further review revealed the following feeding techniques:	W 249		

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W 249	Continued From page 4 a. Monitor for rapid eating pace; b. Provide verbal prompts and if necessary tactile prompts such as hand over hand assistance to place his spoon on the table between each bite of food; c. Shake off excess food from the spoon before placing in his mouth; There was no evidence that the facility implemented Client #1's IPP as recommended.	W 249		
W 252	483.440(e)(1) PROGRAM DOCUMENTATION Data relative to accomplishment of the criteria specified in client individual program plan objectives must be documented in measurable terms. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure program documentation was accurately collected, for one of the three sampled clients. (Client #3) The findings include: (Cross Reference 249). Record review on August 26, 2011, at 11:30 a.m., revealed Client #3's Individual Program Plan (IPP) dated April 25, 2011, required the direct care staff to document the number of times the client was able to spoon feed himself with assistance. Review of the data collection sheet revealed the direct care staff documented hand over hand assistance from	W 252	1&2.All staff were re trained on Mealtime Protocol and IPP. In the future the QDDP and RC, RN and LPN will ensure that staff are observed on at least a weekly basis during mealtimes and there is documentation and teaching completed. See attached mealtime protocol IPP – inservice record	9/21/11

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W 252	Continued From page 5 April 2011 to August 2011. The facility failed to document the number of times Client #3 spoon fed himself with assistance.	W 252	W356 Mr. Lawton had a dental consult in: 4/09 – deep scaling completed 9/09 – adult prophylaxis with polishing completed 12/09 – full mouth scaling completed 6/10 – examined for scaling – authorization 1/11 – full mouth gross debridement and prophylaxis completed. 8/11 – full mouth gross debridement completed. The QDDP has a tooth brushing program and all staff have been in serviced on it. In the future the QDDP and RN will ensure that staff are observed implementing the tooth brushing IPP and document the same. The Director of Nursing has developed a dental appt. tracking form to ensure that such a delay does not occur again. In the future the RN Supervisor will ensure that monthly tracking is completed. See attached – in service record on tooth brushing IPP and dental consults with summary and dental appt. tracking record	9/21/11
W 356	483.460(g)(2) COMPREHENSIVE DENTAL TREATMENT The facility must ensure comprehensive dental treatment services that include dental care needed for relief of pain and infections, restoration of teeth, and maintenance of dental health. This STANDARD is not met as evidenced by: Based on interview, and record review, the facility failed to ensure preventive care for the maintenance dental health, for one of three clients in the sample. (Client #1) The finding includes: Interview with the licensed practical nurse (LPN) on August 26, 2011, at 12:35 p.m., revealed Client #1 had a dental scaling on August 2, 1011. The LPN indicated, however, that there was a thirteen month interval between the time the client was recommended to have the dental scaling and the time the scaling was performed. According to the LPN, the client had the dental assessment in June 2010, however when she called the dental office in December 2010 to obtain an appointment date for the scaling, she was informed that the authorization for the scaling had not been received from the funding agency. Record review on August 26, 2011, beginning at	W 356		

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W 356	Continued From page 6 1:45 p.m., revealed the following information concerning Client #1's professional dental services: a. June 21, 2010 - Perio-probing revealed generalized bleeding. Non-verbal patient, very uncooperative. Does not follow commands, therefore was unable to take a Panorex x-ray. Needs scaling. Will submit request for authorization and call to schedule appointment after authorization is received. b. August 2, 2011 (13 months later) - Oral exam; heavy tartar, heavy plaque, heavy bleeding. Full mouth gross debridement and prophylaxis. Client referred for a dental x-ray. Please assist patient in brushing teeth at 2-3 times daily. At the time of the survey, there was no evidence that Client #1 had received timely treatment services for the maintenance of his dental health.	W 356		
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that recommended assistive devices was maintained in good repair for two of three clients in the sample. (Clients #1 and #2)	W 436	W436 1. The QDDP will ensure that staff are trained and are able to monitor the correct use of the elbow pads and the foot box. The QDDP will ensure that the staff document on a daily basis the condition of each adaptive equipment being used by the individuals. 2. The foot box has been replaced and staff have been in serviced on the adaptive equipment policy and procedure and the daily tracking form See attached in service record on daily adaptive equipment monitoring	9/21/11

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W 436	Continued From page 7	W 436		

The findings include:

1. The facility failed to ensure that Client #1's arm pads were maintained in good condition, as evidenced below:
On August 25, 2011, at 7:55 a.m., a healed white scar was observed on Client #1's left elbow, as he sat in the recliner watching the television. At 11:00 a.m., on the same day, the client was observed wearing an arm pad, which fit loosely on his left arm, above the elbow.
Interview with the Qualified Intellectual Developmental Professional (QIDP) on August 25, 2011, at 9:53 a.m., revealed that on July 21,2011, Client #1 sustained the aforementioned injury to his left elbow when he fell while ambulating in the living room. The QIDP indicated that the client was recommended to wear elbow pads, due to his unsteady gait. According to the QIDP, however, the elbow pads had a tendency to stretch, and may not have been on the client's elbow when he fell.
Interview with the day program staff on August 25, 2011, at 11:08 a.m., revealed that the client's elbow pads fit loosely, and that it was necessary to reposition them frequently to ensure that they remained on his elbow.
On August 25, 2011, at 9:59 a.m., the review of an unusual incident report dated July 21,2011, confirmed that Client #1 that the aforementioned injury to his left elbow occurred when he fell. On the same day, at 4:45 p.m., review of the unusual incident investigation report dated July 25, 2011, confirmed that on July 21, 2011, the client fell on the floor and injured his elbow when he was walking in the living room. A physical therapy assessment dated October 21, 2010, revealed

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W 436	Continued From page 8 the client should ambulate using his gait belt, while wearing elbow and knee pads as tolerated. On August 26, 2011, at approximately 4:00 p.m., the QIDP presented a pair of elbow pads, which she stated were purchased as a replacement for Client #1 on August 25, 2011. At the time of the survey, however, the facility failed to ensure that Client #1's elbow pads were consistently maintained in good repair to be worn as prescribed. 2. On August 25, 2011, at 5:13 p.m., the direct support staff wheeled Client #2 into the living room. The client's legs were observed hanging over two pillows that were stacked on top of each other in his foot box. At approximately 5:20 p.m., another direct support staff wheeled the client to his bedroom to change his clothes. At 5:48 p.m., the direct support staff wheeled Client #2 back into the living room. Further observation revealed the client's feet were placed on one pillow and the other pillow was placed vertically behind his legs in the footrest. On August 26, 2011, at approximately 10:00 a.m., review of Client #2's physical therapy (PT) note dated July 1, 2011, revealed that staff must ensure that the client is properly position. Staff should use two small pillows in the foot box to support his lower extremity because the current foot box needs to be adjusted. Further review of the PT note revealed that staff was trained on the proper usage and positioning of Client #2's wheelchair. Interview with the qualified intellectual developmental professional (QIDP) on August 26, 2011, at 10:35 a.m., revealed that the wheelchair	W 436		

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W 436	Continued From page 9 vendor was waiting for a part for the client's foot box. Further interview revealed that she tried to contact the vendor minutes before the interview, to determine what day the footbox will be repaired. The facility failed to ensure timely adjustments in Client #2's footbox as recommended by the physical therapist.	W 436		

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I 000	INITIAL COMMENTS A relicensure survey was conducted from August 24, 2011 through August 26, 2011. A sampling of three residents was selected from a population of five males with cognitive and intellectual disabilities. This survey was conducted utilizing the fundamental survey process. The findings of the survey were based on observations and interviews with staff in the home and at two day programs, as well as a review of resident and administrative records, including incident and investigation reports. [Qualified Mental Retardation Professional(QMRP) will be referred as Qualified Intellectual Disabilities Professional (QIDP) within this report.	I 000		
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation and staff interview, the group home for persons with intellectual disabilities (GHPID) failed to maintain the facility's environment as required to ensure the health and safety of five of five residents. (Residents #1, #2, #3,#4, and #5) The findings include: Observation and interview with the facility's house manager, (HM) on August 25, 2011, beginning at 9:30 a.m., revealed the following deficient	I 090	I090 1. The area around the vent was re painted. 2. All additional adaptive equipment not being utilized by the individuals has been put away in storage. 3. The toilet set has been replaced. 4. The living room sofa has been replaced. 5. Individual #5 – dresser drawer has been fixed. 6. The wood frame around the exterior window sill has been replaced. In the future the QDDP and RC will ensure that monthly environmental audits are completed so that these issues do not re occur.	9/20/11

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I 090	Continued From page 1 conditions: 1. There was chipping and peeling paint around the vent in the entrance hall ceiling. 2. In the first floor bathroom, there was a gurney that was not being used. Also, in the front storage room there were seven (7) broken wheel chairs. 3. Bathroom #1 had a broken toilet seat. 4. In the living room, the lounge chair had torn leather on the head rest and armrest. 5. In Resident #5's bedroom, the dresser drawer would not close properly. 6. There was a rotten piece of wood on an exterior window sill. The window was located on the right side of the front entrance door to the facility.	I 090		
I 180	3508.1 ADMINISTRATIVE SUPPORT Each GHMRP shall provide adequate administrative support to efficiently meet the needs of the residents as required by their Habilitation plans. This Statute is not met as evidenced by: Based on observation, interview, and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure that each resident's active treatment program was coordinated, integrated and monitored by the Qualified Intellectual Disabilities Professional (QIDP), for three residents in the sample (Residents #1, #2, and #3). The findings include:	I 180	I180 1. The QDDP will ensure that staff are trained and are able to monitor the correct use of the elbow pads and the foot box. The QDDP will ensure that the staff documents the condition of each adaptive equipment being used by the individuals, on a daily basis. 2.The foot box has been replaced and staff have been in serviced on the adaptive equipment policy and procedure and the daily tracking form 3.All staff were re trained on Mealtime Protocol and IPP. 4.All staff were in serviced on IPP documentation and accurate data collection. In the future the QDDP and the RC/RN will ensure that they monitor the staff during mealtimes at least 2x/week, to ensure that the mealtime protocol is being followed and that staff document the program data accurately. In the future the QDDP and RC, RN and LPN will ensure that staff are observed on at least a weekly basis during mealtimes and there is documentation and teaching completed. See attached mealtime protocol IPP – inservice record, record on daily adaptive equipment monitoring, and IPP documentation	9/21/11

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I 180	Continued From page 2 1. Cross refer to federal deficiency report citation - W436.1 The facility's QIDP failed to coordinate services to ensure Resident #1's elbow pads were maintained in good repair. 2. Cross refer to federal deficiency report citation - W436.2 The facility's QIDP failed to coordinate services to ensure Resident #2's wheelchair footbox was maintained in good repair. 3. Cross refer to W249. The facility's QIDP failed to ensure Residents #1 and #3 received continuous active treatment. 4. Cross refer to W252. The facility's QIDP failed to ensure program documentation was accurately collected for Resident #3.	I 180		
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on observation, interview, and record review, the group home for persons with intellectual disabilities (GHPID) failed to ensure professional services that included both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident for one of three residents in the sample. (Resident #1)	I 401		

Health Regulation & Licensing Administration

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	09G219	A. BUILDING _____ B. WING _____	08/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METRO HOMES, INC	615 55TH STREET, NE WASHINGTON, DC 20019

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I 401	Continued From page 3 The finding includes: The facility failed to ensure preventive care for the maintenance dental health, for Resident #1. Interview with the licensed practical nurse (LPN) on August 26, 2011, at 12:35 p.m., revealed Resident #1 had a dental scaling on August 2, 1011. The LPN indicated, however, that there was a thirteen month interval between the time the resident was recommended to have the dental scaling and the time the scaling was performed. According to the LPN, the resident had the dental assessment in June 2010, however when she called the dental office in December 2010 to obtain an appointment date for the scaling, she was informed that the authorization for the scaling had not been received from the funding agency. Record review on August 26, 2011, beginning at 1:45 p.m., revealed the following information concerning Resident #1's professional dental services: a. June 21, 2010 - Perio-probing revealed generalized bleeding. Non-verbal patient, very uncooperative. Does not follow commands, therefore was unable to take a Panorex x-ray. Needs scaling. Will submit request for authorization and call to schedule appointment after authorization is received. b. August 2, 2011 (13 months later) - Oral exam; heavy tartar, heavy plaque, heavy bleeding. Full mouth gross debridement and prophylaxis. Resident referred for a dental x-ray. Please assist patient in brushing teeth at 2-3 times daily.	I 401	wton had a dental consult in: 4/09 – deep scaling completed 9/09 – adult prophylaxis with polishing completed 12/09 – full mouth scaling completed 6/10 – examined for scaling – authorization 1/11 – full mouth gross debridement and prophylaxis completed. 8/11 – full mouth gross debridement completed. The QDDP has a toothbrushing program and all staff have been in serviced on it. In the future the QDDP and RN will ensure that staff are observed implementing the toothbrushing IPP and document the same. The Director of Nursing has developed a dental appt. tracking form to ensure that such a delay does not occur again. In the future the RN Supervisor will ensure that monthly tracking is completed. See attached – in service record on tooth brushing IPP and dental consults with summary and dental appt. tracking form	9/20/11

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I 401	Continued From page 4 At the time of the survey, there was no evidence that Resident #1 had received timely treatment services for the maintenance of his dental health.	I 401		
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident ' s Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, staff interview and record verification, the facility's staff failed to ensure that residents' training objectives were implemented in accordance with their Individual Support Plan (ISP), for two of the three residents in the sample. (Resident #1 and #3) The findings include: 1. On August 25, 2011, beginning at 6:36 p.m., the direct support staff was observed feeding Resident #3 his dinner with hand over hand assistance. One minute later, the direct support staff placed the resident's spout cup in his mouth without the use of hand over hand assistance. At 6:46 p.m., the direct support staff began to feed the resident his meal without hand over hand assistance. At 6:55 p.m., the direct support staff spoon fed the resident his chocolate pudding. Interview with the direct support staff on August 25, 2011, at 7:05 p.m., revealed she " did not think the resident wanted to hold his built up handle spoon. " Review of Resident #3's occupational assessment dated April 24, 2011 on August 26, 2011, at approximately 10:45 a.m., revealed the	I 422	I422 The staff have been disciplined and re trained in both the individual's mealtime protocols. In the future the QDDP and the RC/RN will ensure that they monitor the staff during mealtimes at least 2x/week, to ensure that the mealtime protocol is being followed. See attached mealtime and IPP in service record	9/21/11

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resident will hold his spoon and participate with assistance.

Review of Resident #3's individual program plan (IPP) dated April 25, 2011 on August 26, 2011, at 11:00 a.m., revealed an objective that stated, "Given hand over hand assistance, [the resident] will feed himself with five spoons during meals on 80% of trials for six consecutive months by April 2012." Further review of the IPP revealed the following steps:

a. The resident will be verbally prompted by staff to hold his spoon;

b. Staff will assist to scoop food on spoon and gently prompt the resident to bring food to his mouth;

c. Staff will encourage and reinforce the resident when he completes directives;

d. Staff will allow the resident to perform as his level permits and document the number of times;

Interview with the QIDP on August 26, 2011 at approximately 10:30 a.m., revealed she will retrain the staff on Resident #3's IPP.

There was no evidence that the facility implemented Resident #3's IPP as recommended.

2. On August 25, 2011, beginning at 6:38 p.m., Resident #1 was observed eating at a fast pace. At 6:42 p.m., the resident drank water as the house manager placed the spout cup to his mouth. The resident then began to eat at a fast pace again. The house manager gently placed her hand on top of his left hand as the resident

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ate fast with his right hand. At 6:44 p.m., the house manager asked the resident to slow down. The resident then began to feed himself at a slower pace with verbal prompting. At 6:52 p.m., the house manager began to feed the resident the rest of his dinner. At 6:54 p.m., the house manager spoon fed the resident his chocolate pudding.

Interview with the house manager on the same day at 7:00 p.m., revealed the resident eats fast and she "did not want his food to get everywhere".

Review of Resident #1's occupational assessment dated November 4, 2010 on August 26, 2011, at 9:20 a.m., revealed the resident eats fast and needs prompts from staff to slow down.

On the same day, at approximately 9:30 a.m., review of Resident #1's IPP dated November 1, 2010, revealed an objective that stated, "Given verbal prompts, [the resident] will eat at a slow pace during meals on 80% of trials for six consecutive months by November 2011". Further review revealed the following feeding techniques:

a. Monitor for rapid eating pace;

b. Provide verbal prompts and if necessary tactile prompts such as hand over hand assistance to place his spoon on the table between each bite of food;

c. Shake off excess food from the spoon before placing in his mouth;

There was no evidence that the facility implemented Resident #1's IPP as recommended.

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